

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-032805

AMENDED

Registration District No.

149 Primary Registration District No. 1002

Registrar's No.

4762

STATE FILE NUMBER

FILED OCT 11 1961

1. PLACE OF DEATH

a. COUNTY

Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN
Kansas City

Length of stay in 1b

40 yrs

c. CITY

OR TOWN
Kansas City

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR

INSTITUTION
Osteopathic Hospital

Inside Limits

Yes ☒ No ☐

d. STREET

ADDRESS

(If outside, give location)

304 Ord

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Essie

Middle

N.

Last

Davenport

4. DATE OF DEATH

Month

Day

Year

9-22-61

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☒Never Married ☐Widowed ☐Divorced ☐

8. DATE OF BIRTH

11-10-15

9. AGE (last birthday)

45

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Kansas City, Mo.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

James Boyd

13b. MOTHER'S MAIDEN NAME

Martha Davis

14. NAME OF HUSBAND OR WIFE

George B. Davenport

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

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17. INFORMANT

Address

George B. Davenport. 304 Ord

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Circulatory failure

INTERVAL BETWEEN ONSET AND DEATH

HOURS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Mitral Stenosis with insufficiency

YEARS

DUE TO (c)

Rheumatic Heart Disease

YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes☐ No☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

9-21-61

to

9-22-61

and last saw her

9/22/61

Death occurred at

12:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Wilton S. Steinberg D.O.

22b. ADDRESS

926 E. 11th Street K.C. Mo.

22c. DATE SIGNED

9-23-61

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

9-25-61

23c. NAME OF CEMETERY OR CREMATORY

Mt. Moriah Cemetery

23d. LOCATION (City, town, or county)

Kansas City, Missouri

24. FUNERAL DIRECTOR

ADDRESS

Sheil Funeral Home K. C. Missouri

25. DATE RECD. BY LOCAL REG.

9-25-61

26. REGISTRAR'S SIGNATURE

Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John P. Shuch

Licensed Embalmer No. 5070

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.